		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040410

Facility Name: Elmwood Care

Address: 7733 W. Grand Ave (Number) Elmwood Park (City) 60635 (Zip Code)

County: Cook

Telephone Number: (708) 452-9200 **Fax #** (708) 452-9294

IDPA ID Number: 363868389001

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	58,689	10,976	7,002	76,667	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,689	10,976	7,002	76,667	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.73%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 64 and days of care provided 7,002

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	265,869	65,073	39,996	370,938		370,938	(22,945)	347,993			1
2	Food Purchase		348,981		348,981	(38,150)	310,831	(497)	310,334			2
3	Housekeeping	229,849	43,683		273,532		273,532	(1,145)	272,387			3
4	Laundry	47,593	35,692		83,285		83,285		83,285			4
5	Heat and Other Utilities			188,452	188,452		188,452	(1,238)	187,214			5
6	Maintenance	50,723	21,914	121,673	194,310		194,310	(33,403)	160,907			6
7	Other (specify):*							6,386	6,386			7
8	**TOTAL General Services**	594,034	515,343	350,121	1,459,498	(38,150)	1,421,348	(52,841)	1,368,507			8
	B. Health Care and Programs											
9	Medical Director			12,800	12,800		12,800		12,800			9
10	Nursing and Medical Records	2,583,127	276,914	296,633	3,156,674		3,156,674	(60,937)	3,095,737			10
10a	Therapy	73,877	2,483	16,701	93,061		93,061		93,061			10a
11	Activities	93,668	5,475	1,968	101,111		101,111		101,111			11
12	Social Services	100,017		4,278	104,295		104,295		104,295			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							5,114	5,114			15
16	**TOTAL Health Care and Programs**	2,850,689	284,872	332,380	3,467,941		3,467,941	(55,823)	3,412,118			16
	C. General Administration											
17	Administrative	135,576		572,135	707,711		707,711	(480,094)	227,617			17
18	Directors Fees											18
19	Professional Services			198,452	198,452	(162)	198,290	(135,699)	62,591			19
20	Dues, Fees, Subscriptions & Promotions			71,543	71,543		71,543	(45,742)	25,801			20
21	Clerical & General Office Expenses	109,787	37,017	114,998	261,802		261,802	(1,832)	259,970			21
22	Employee Benefits & Payroll Taxes			567,766	567,766	38,150	605,916	(407)	605,508			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,379	10,379		10,379	573	10,952			24
25	Other Admin. Staff Transportation			981	981		981	3,354	4,335			25
26	Insurance-Prop.Liab.Malpractice			204,161	204,161		204,161	1,343	205,504			26
27	Other (specify):*							24,567	24,567			27
28	**TOTAL General Administration**	245,363	37,017	1,740,415	2,022,795	37,988	2,060,783	(633,937)	1,426,845			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,690,086	837,232	2,422,916	6,950,234	(162)	6,950,072	(742,601)	6,207,471			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Elmwood Care #0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			87,388	87,388		87,388	351,735	439,123			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,004	26,004		26,004	759,902	785,906			32
33	Real Estate Taxes			426,790	426,790	162	426,952	7,239	434,191			33
34	Rent-Facility & Grounds			756,600	756,600		756,600	(756,600)				34
35	Rent-Equipment & Vehicles			3,711	3,711		3,711	7,590	11,301			35
36	Other (specify):*							19,385	19,385			36
37	**TOTAL Ownership**			1,300,493	1,300,493	162	1,300,655	389,251	1,689,906			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	98,271	369,716	403,441	871,428		871,428	(24,090)	847,338			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			134,137	134,137		134,137		134,137			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	98,271	369,716	537,578	1,005,565		1,005,565	(24,090)	981,475			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,788,357	1,206,948	4,260,987	9,256,292		9,256,292	(377,440)	8,878,852			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,134)	30		9
10	Interest and Other Investment Income	(587)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(497)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(985)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(55,777)	21		24
25	Fund Raising, Advertising and Promotional	(25,986)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(16,081)	20		28
29	Other-Attach Schedule	(55,202)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (158,249)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(219,191)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (219,191)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (377,440)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Elmwood Care

ID# 0040410

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Prescription Drugs - Veterans	$ (9,355)	10	1
2	Purchased Services - Veterans	(42)	10	2
3	Theft & Damage	(1,330)	21	3
4	Cable TV	(3,795)	05	4
5	Trust Fees	(150)	21	5
6	State Replacement Tax	(6,524)	21	6
7	IL Council on LTC - COPE Dues	(3,005)	20	7
8	Miscellaneous Income - Jury Duty	(17)	21	8
9	Capitalized R&M	(16,122)	06	9
10	Legal (Prior Year & Non-allowable	(12,544)	19	10
11	Prior Period Adjustment	(2,318)	21	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91
92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	**Total**	(55,202)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary					(22,880)		(65)					(22,945)	1
2	Food Purchase	(497)											(497)	2
3	Housekeeping			777				(1,922)					(1,145)	3
4	Laundry													4
5	Heat and Other Utilities	(3,795)		1,002	1,555								(1,238)	5
6	Maintenance	(16,122)		791	(14,654)	(3,418)							(33,403)	6
7	Other (specify):*				1,159	5,227							6,386	7
8	**TOTAL General Services**	(20,414)		2,570	(11,940)	(21,071)		(1,987)					(52,841)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(9,397)			(24,482)			(27,058)					(60,937)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				5,114								5,114	15
16	**TOTAL Health Care and Programs**	(9,397)			(19,368)			(27,058)					(55,823)	16
	C. General Administration													
17	Administrative			19,253	(75,645)	(423,690)			(12)				(480,094)	17
18	Directors Fees													18
19	Professional Services	(12,544)		(113,893)	(19,567)	10,305							(135,699)	19
20	Fees, Subscriptions & Promotions	(46,057)		223	92								(45,742)	20
21	Clerical & General Office Expenses	(66,116)		63,594	690								(1,832)	21
22	Employee Benefits & Payroll Taxes						(395)		(12)				(407)	22
23	Inservice Training & Education													23
24	Travel and Seminar			188	385								573	24
25	Other Admin. Staff Transportation			874	2,480								3,354	25
26	Insurance-Prop.Liab.Malpractice			442	901								1,343	26
27	Other (specify):*			11,317	3,851	9,399							24,567	27
28	**TOTAL General Administration**	(124,717)		(18,002)	(86,813)	(403,986)	(395)		(24)				(633,937)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(154,528)		(15,432)	(118,121)	(425,057)	(395)	(29,044)	(24)				(742,601)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elmwood Care # 0040410 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(3,134)	257,441	2,791	94,637								351,735	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(587)	756,600	761	3,128								759,902	32
33	Real Estate Taxes			2,569	4,670								7,239	33
34	Rent-Facility & Grounds		(756,600)										(756,600)	34
35	Rent-Equipment & Vehicles			2,516	5,074								7,590	35
36	Other (specify):*		19,385										19,385	36
37	**TOTAL Ownership**	(3,721)	276,826	8,637	107,509								389,251	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(24,090)								(24,090)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**				(24,090)								(24,090)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(158,249)	276,826	(6,795)	(34,702)	(425,057)	(395)	(29,044)	(24)				(377,440)	45

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule		See Attached Schedule		See Attached	Lincolnwood	Building
				Elmwood Care Bldg, LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 756,600	Elmwood Building, LLC	100.00%	$	$ (756,600)	1
2	V	36	Amortization		Elmwood Building, LLC		19,385	19,385	2
3	V	30	Depreciation		Elmwood Building, LLC		257,441	257,441	3
4	V	32	Interest Expense		Elmwood Building, LLC		756,600	756,600	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 756,600			$ 1,033,426	$ * 276,826	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 777	$ 777	15
16	V		5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,002	1,002	16
17	V		6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	791	791	17
18	V		17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	19,253	19,253	18
19	V		19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	2,457	2,457	19
20	V		20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	223	223	20
21	V		21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	63,594	63,594	21
22	V		24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	188	188	22
23	V		25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	874	874	23
24	V		26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	442	442	24
25	V		27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	11,317	11,317	25
26	V		30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,791	2,791	26
27	V		32	INTEREST		PREFERRED BOOKKEEPING	100.00%	761	761	27
28	V		33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,569	2,569	28
29	V		35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,516	2,516	29
30	V									30
31	V									31
32	V		19	ACCOUNT./BOOKKEEPING	116,350	PREFERRED BOOKKEEPING	100.00%		(116,350)	32
33	V		19	COMPUTER	5,880	PREFERRED BOOKKEEPING	100.00%	5,880		33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 122,230			$ 115,435	$ * (6,795)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,555	$ 1,555	15
16	V	6	REPAIRS AND MAINT.	22,056	S.I.R. MANAGEMENT, INC.	100.00%	7,402	(14,654)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,159	1,159	17
18	V	10	NURSING	48,516	S.I.R. MANAGEMENT, INC.	100.00%	24,034	(24,482)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	5,114	5,114	19
20	V	17	ADMINISTRATIVE	85,968	S.I.R. MANAGEMENT, INC.	100.00%	10,323	(75,645)	20
21	V	19	PROFESSIONAL FEES	19,848	S.I.R. MANAGEMENT, INC.	100.00%	281	(19,567)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	92	92	22
23	V	21	CLERICAL & GENERAL	24,996	S.I.R. MANAGEMENT, INC.	100.00%	25,686	690	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	385	385	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,480	2,480	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	901	901	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,851	3,851	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,539	3,539	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,128	3,128	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,670	4,670	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	5,074	5,074	31
32	V								32
33	V	39	LEASED EQUIPMENT	24,090	S.I.R. MANAGEMENT, INC.	100.00%		(24,090)	33
34	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	91,098	91,098	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 225,474			$ 190,772	$ * (34,702)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 24,996	S.I.R. MANAGEMENT, INC.	100.00%	$ 7,580	$ (17,416)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,612	1,612	16
17	V	17	ADMIN./LEGAL SALARIES	481,847	S.I.R. MANAGEMENT, INC.	100.00%	62,477	(419,370)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	16,185	16,185	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	9,399	9,399	19
20	V								20
21	V	17	ADMIN. SALARY		S.I.R. MANAGEMENT, INC.	100.00%			21
22	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%			22
23	V								23
24	V	17	ADMIN SALARY		S.I.R. MANAGEMENT, INC.	100.00%			24
25	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%			25
26	V								26
27	V	10A	SPECIAL REHAB		S.I.R. MANAGEMENT, INC.	100.00%			27
28	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%			28
29	V								29
30	V	6	REPAIRS AND MAINT.	10,836	S.I.R. MANAGEMENT, INC.	100.00%	7,418	(3,418)	30
31	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,578	1,578	31
32	V								32
33	V	1	DIETICIAN SALARIES	15,000	S.I.R. MANAGEMENT, INC.	100.00%	9,536	(5,464)	33
34	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,037	2,037	34
35	V								35
36	V	19	LEGAL FEES	5,880	S.I.R. MANAGEMENT, INC.	100.00%		(5,880)	36
37	V								37
38	V	17	COUNCIL DUES	4,320	S.I.R. MANAGEMENT, INC.	100.00%		(4,320)	38
39	Total			$ 542,879			$ 117,822	$ * (425,057)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 93,731	$ 93,731	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	94,126	CCS EMPLOYEE BENEFIT GROUP	100.00%		(94,126)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 94,126			$ 93,731	$ * (395)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 494	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 429	$ (65)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	14,600	XCEL MEDICAL SUPPLY, LLC	100.00%	12,678	(1,922)	17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%			19
20	V	10	NURSING	205,562	XCEL MEDICAL SUPPLY, LLC	100.00%	178,504	(27,058)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39	ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%			25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 220,656			$ 191,612	$ * (29,044)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	HEALTH INSURANCE	$ 12,320	ECM OWNERS COUNCIL	100.00%	$ 12,220	$ (100)	15
16	V	17	ADMINISTRATOR SALARY	7,920	ECM OWNERS COUNCIL	100.00%	7,908	(12)	16
17	V	22	PAYROLL TAXES	600	ECM OWNERS COUNCIL	100.00%	688	88	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 20,840			$ 20,816	$ * (24)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Nenita Guzman	Relative	Dietary	0%	See Attached	5.97	11.94%	Alloc Salary	$ 7,580	1-7	1
2	Louise Bergthold	Shareholder	Administrative	4.90%	See Attached	6.57	11.95%	Alloc Salary	21,297	17-7	2
3	Tom Winter	Shareholder	Administrative	1.43%	See Attached	7.46	12.43%	Alloc Salary	19,253	17-7	3
4	Jeff Oravec	Shareholder	Administrative	0.41%	See Attached	4.78	11.95%	Alloc Salary	11,168	17-7	4
5	Joey Abramchik	Shareholder	Administrative	2.04%	See Attached	5.38	11.96%	Alloc Salary	16,185	17-7	5
6	Stuart Sikes	Shareholder	Administrative	0.82%	See Attached	4.78	11.95%	Alloc Salary	14,267	17-7	6
7	Lori Barrish	Shareholder	Administrative	2.04%	None	40.00	100.00%	Salary	89,082	17-1	7
8	Adam Vales	Relative	Clerical	0%	See Attached	0.48	1.20%	Alloc Salary	375	22-7	8
9	Eric Rothner	Shareholder	Administrative		See Attached	0.66	1.20%	Alloc Salary	17,237	17-7	9
10											10
11											11
12											12
13								TOTAL	$ 196,444		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	935,658	11	$ 6,250	$	116,350	$ 777	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	935,658	11	8,058		116,350	1,002	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	935,658	11	6,361		116,350	791	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	935,658	11	154,828	154,828	116,350	19,253	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	935,658	11	19,761		116,350	2,457	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	935,658	11	1,793		116,350	223	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	935,658	11	511,408	453,848	116,350	63,594	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	935,658	11	1,508		116,350	188	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	935,658	11	7,028		116,350	874	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	935,658	11	3,553		116,350	442	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	935,658	11	91,005		116,350	11,317	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	935,658	11	22,443		116,350	2,791	12
13	32	INTEREST	BOOK./ACCNT.INCOME	935,658	11	6,117		116,350	761	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	935,658	11	20,656		116,350	2,569	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	935,658	11	20,229		116,350	2,516	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						5,880	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 880,998	$ 608,675		$ 115,435	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	641,706	10	$ 13,016	$	76,667	$ 1,555	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	641,706	10	61,951	45,622	76,667	7,402	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	641,706	10	9,705		76,667	1,159	3
4	10	NURSING	PATIENT DAYS	641,706	10	201,162	201,162	76,667	24,034	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	641,706	10	42,801		76,667	5,114	5
6	17	ADMINISTRATIVE	PATIENT DAYS	641,706	10	86,401	86,401	76,667	10,323	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	641,706	10	2,349		76,667	281	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	641,706	10	773		76,667	92	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	641,706	10	214,995	167,138	76,667	25,686	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	641,706	10	3,219		76,667	385	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	641,706	10	20,755		76,667	2,480	11
12	26	INSURANCE	PATIENT DAYS	641,706	10	7,541		76,667	901	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	641,706	10	32,233		76,667	3,851	13
14	30	DEPRECIATION	PATIENT DAYS	641,706	10	29,623		76,667	3,539	14
15	32	INTEREST	PATIENT DAYS	641,706	10	26,178		76,667	3,128	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	641,706	10	39,087		76,667	4,670	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	641,706	10	42,473		76,667	5,074	17
18										18
19	35	LEASED EQUIPMENT	LEASING INCOME	24,090	1			24,090		19
20	30	DEPRECIATION	LEASING INCOME	24,090	1	91,098		24,090	91,098	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 925,360	$ 500,323		$ 190,772	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	641,706	10	$ 63,448	$ 63,448	76,667	$ 7,580	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	641,706	10	13,496		76,667	1,612	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	641,706	10	522,936	522,936	76,667	62,477	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	641,706	10	135,472		76,667	16,185	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	641,706	10	$ 78,674	$	76,667	$ 9,399	5
6										6
7	17	ADMIN. SALARY	AVG HRS WKD	30	5	170,502	170,502			7
8	27	EMP. BEN.-ADMIN.	AVG HRS WKD	30	5	28,886				8
9						$	$		$	9
10	17	ADMIN SALARY	AVG HRS WKD	30	5	151,372	151,372			10
11	27	EMP. BEN.-ADMIN.	AVG HRS WKD	30	5	28,244				11
12										12
13	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	$ 62,910	$ 62,910		$	13
14	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	107,736	7	13,382				14
15										15
16	6	REPAIRS AND MAINT.	MAINTENANCE INC.	163,332	10	111,809	111,809	10,836	7,418	16
17	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	163,332	10	23,783		10,836	1,578	17
18										18
19	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	79,717	79,717	15,000	9,536	19
20	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	17,031		15,000	2,037	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,501,663	$ 1,162,695		$ 117,822	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 93,731	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 93,731	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 429	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						12,678	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation							5
6	10	NURSING	Direct Allocation						178,504	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation							10
11	39	ANCILLARY	Direct Allocation							11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 191,612	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60646
Phone Number: (847) 676-2026
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	HEALTH INSURANCE	DIRECT ALLOCATION		4	$	$		$ 12,220	1
2	17	ADMINISTRATOR SALARY	DIRECT ALLOCATION		4				7,908	2
3	22	PAYROLL TAXES	DIRECT ALLOCATION		4				688	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 20,816	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	CIB Bank-LOC		X	Working Capital		6/20/03		1,325,000	08/20/04	5.25%	782,604	6
7	Allocation-SIR & Preferred		X	Working Capital							3,889	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 1,325,000			$ 786,493	9
	B. Non-Facility Related*											
10												10
11	Interest Income		X								(587)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (587)	14
15	TOTALS (line 9+line14)						$	$ 1,325,000			$ 785,906	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0.00 Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	420,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	425,629	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,029	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	429,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	162	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	434,191	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	427,944	8
	1999	461,646	9
	2000	435,020	10
	2001	410,298	11
	2002	418,390	12

RE Tax Accrual - 418,390*1.03=$429,000

SIR Real Estate Allocation - $4,103.12

Preferred Real Estate Allocation - $2,256.79

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040410

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-25-323-001-0000	Long Term Care Property	$ 5,519.00	$ 5,519.00
2.	12-25-324-002-0000	Long Term Care Property	$ 2,232.28	$ 2,232.28
3.	12-25-323-003-0000	Long Term Care Property	$ 115,417.17	$ 115,417.17
4.	12-25-323-004-0000	Long Term Care Property	$ 115,090.94	$ 115,090.94
5.	12-25-323-005-0000	Long Term Care Property	$ 180,130.96	$ 180,130.96
6.	Allocation of 2002 RE Taxes	SIR Management (See Attached)	$ 74,287.87	$ 6,359.91
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 492,678.22	$ 424,750.26

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Elmwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040410

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,565 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1993	$ 627,991	1
2			1998	100,000	2
3	TOTALS			$ 727,991	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	129,203		20	6,460	6,460	66,445	9
10	Various			1994	49,738		20	2,487	2,487	23,733	10
11	Various			1995	167,102		20	8,357	8,357	71,314	11
12	Various			1996	136,090		20	6,804	(6,804)	50,097	12
13	Various			1997	16,180		20	809	809	5,297	13
14	Various			1998	161,911		20	9,183	9,183	51,672	14
15	Various			1999	138,019		20	6,902	6,902	30,782	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		10,419,509	257,441		297,700	40,259	2,825,007	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		100,063	3,414		3,948	534	33,632	68
69	Financial Statement Depreciation			13,903			(13,903)		69
70	TOTAL (lines 4 thru 69)		$ 11,317,815	$ 274,758		$ 342,650	$ 54,284	$ 3,157,979	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 11,317,815	$ 274,758		$ 342,650	$ 67,892	$ 3,157,979	1
2	Fire Panel	2000	8,650		20	433	433	1,659	2
3	Hvac Work	2000	9,373		20	469	469	1,680	3
4	Hvac Work	2000	12,416		20	621	621	2,174	4
5	Electrical Wiring	2000	7,700		20	385	385	1,412	5
6	Electrical Wiring	2000	4,800		20	240	240	820	6
7	Sewer Work	2000	2,800		20	140	140	502	7
8	Jrc Sewer	2000	2,250		20	113	113	376	8
9	Freezer Work	2000	2,455		20	123	123	410	9
10	Doors	2000	4,012		20	201	201	652	10
11	Sewer	2000	850		20	43	43	128	11
12	Tile	2000	1,371		20	69	69	206	12
13	Drywall	2000	1,085		20	54	54	163	13
14	Mixing Valve	2000	753		20	38	38	113	14
15	Pump	2000	1,778		20	89	89	267	15
16	Paint	2000	688		20	34	34	103	16
17	Wiring	2000	1,226		20	61	61	184	17
18	Block Heater	2000	1,044		20	52	52	156	18
19	Plumbing	2000	675		20	34	34	102	19
20	Painting	2000	650		20	33	33	98	20
21	Privacy Curtains	2000	926		20	46	46	139	21
22	Bearing Assembly	2000	1,242		20	62	62	212	22
23	1/12 Hp Motor	2000	839		20	42	42	144	23
24	Roofing	2001	46,330		20	2,317	2,317	6,950	24
25	Sewer Work	2001	3,800		20	190	190	491	25
26	Roofing	2001	12,940		20	647	647	1,564	26
27	Wet Work	2001	26,148		20	1,307	1,307	2,724	27
28	Hot Water Piping	2001	2,519		20	126	126	368	28
29	Compressor-Valves	2001	1,323		20	66	66	176	29
30	Concrete Chimney	2001	2,575		20	129	129	290	30
31	Pulley & Belt	2001	1,247		20	62	62	135	31
32	Thermocoupler	2001	1,528		20	76	76	166	32
33	Hex Bolt	2001	1,380		20	69	69	144	33
34	TOTAL (lines 1 thru 33)		$ 11,485,188	$ 274,758		$ 351,021	$ 76,263	$ 3,182,687	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,485,188	$ 274,758		$ 351,021	$ 76,263	$ 3,182,687	1
2	Wallpaper Border	2001	2,996		20	150	150	313	2
3	Concrete Pation& Bas	2001	3,800		20	190	190	507	3
4	Custom Diffuser	2001	1,068		20	53	53	156	4
5	Ventilation	2002	3,291		20	329	329	603	5
6	Fire Dampers	2002	25,372		20	2,537	2,537	2,960	6
7	Fire Dampers	2002	1,840		20	184	184	215	7
8	Dialysis Room	2002	14,077		20	1,408	1,408	1,525	8
9	Hvac Room	2002	2,326		20	233	233	465	9
10	Hvac Work	2002	25,413		20	2,541	2,541	5,083	10
11	Water Heaters	2002	10,500		20	1,050	1,050	1,488	11
12	A/C Compressor	2002	7,650		20	638	638	956	12
13	Ejector Pump	2002	3,757		20	376	376	532	13
14	Nurse Call	2002	4,578		20	305	305	407	14
15	Chimney Repair	2002	1,017		20	102	102	203	15
16	Generator	2002	1,512		20	151	151	277	16
17	A/C Repair	2002	915		20	92	92	137	17
18	A/C Repair	2002	2,469		20	247	247	370	18
19	Wall Protection	2002	730		20	73	73	110	19
20	Mini-Blinds	2002	816		20	82	82	116	20
21	Hot Water Valves	2002	2,922		20	292	292	341	21
22	Plumbing	2002	1,632		20	163	163	286	22
23	Cubicle Curtains	2002	2,397		20	240	240	459	23
24	Boiler Work	2003	15,650		20	717	717	717	24
25	Boiler Valve	2003	2,576		20	118	118	118	25
26	Exhaust Work	2003	2,541		20	85	85	85	26
27	Electrical Work - Vent	2003	51,700		20	1,508	1,508	1,508	27
28	Vent Alarms (6)	2003	3,894		20	81	81	81	28
29	Vent Alarms (9)	2003	6,352		20	132	132	132	29
30	Kitchen Doors	2003	2,075		20	35	35	35	30
31	Exhaust Work	2003			20				31
32	Piping	2003	2,868		20	96	96	96	32
33	Walk In Freezer	2003	25,014		20	261	261	261	33
34	TOTAL (lines 1 thru 33)		$ 11,718,936	$ 274,758		$ 365,490	$ 90,732	$ 3,203,229	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 11,718,936	$ 274,758		$ 365,490	$ 90,732	$ 3,203,229	1
2	Vent- Alarm 4	2003	2,824		20	24	24	24	2
3	Vent Alarm-3	2003	2,117		20	26	26	26	3
4	Hvac Work	2003	3,329		20	28	28	28	4
5	Compressor & Condensor	2003	1,273		20	64	64		5
6	Boiler Extras	2003	1,097		20	50	50		6
7	Door Screens	2003	1,676		20	35	35		7
8	Sink Valves	2003	1,050		20	18	18		8
9	Cubicle Curtains	2003	3,173		20	40	40		9
10	Stair Treads	2003	1,046		20	4	4		10
11	Exterior Painting	2003	2,415		20	20	20		11
12	Repair Sewer & Drains	2003	1,360		20	45	45		12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,740,296	$ 274,758		$ 365,844	$ 91,086	$ 3,203,307	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1994		$ 10,419,509	$ 257,441		$ 297,700	$ 40,259	$ 2,825,007	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,419,509	$ 257,441		$ 297,700	$ 40,259	$ 2,825,007	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Alloc. SIR Properties		1993		$ 31,924	$ 1,014		$ 912	$ (102)	$ 9,577	4
5	Alloc. SIR Properties		1993		17,559	557		502	(55)	5,268	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation Preferred Bookkeeping			1997	21,929	491	20	1,096	605	7,465	9
10	Allocation Preferred Bookkeeping			1999	174	-	20	9	9	39	10
11	Allocation Preferred Bookkeeping			2000	1,100	-	20	55	55	188	11
12											12
13	Allocation SIR Properties - SIR Management			1993	518	8	20	26	18	272	13
14	Allocation SIR Properties - SIR Management			1994	304	8	20	15	7	144	14
15	Allocation SIR Properties - SIR Management			1997	120	12	20	6	(6)	45	15
16	Allocation SIR Properties - SIR Management			1998	1,933	193	20	97	(96)	532	16
17	Allocation SIR Properties - SIR Management			1999	4,045	405	20	202	(203)	910	17
18	Allocation SIR Properties - SIR Management			2002	126	-	20	6	6	10	18
19											19
20	Allocation SIR Properties - Preferred Bookkeeping			1993	285	5	20	14	9	150	20
21	Allocation SIR Properties - Preferred Bookkeeping			1994	167	4	20	8	4	79	21
22	Allocation SIR Properties - Preferred Bookkeeping			1997	66	7	20	3	(4)	25	22
23	Allocation SIR Properties - Preferred Bookkeeping			1998	1,063	106	20	53	(53)	292	23
24	Allocation SIR Properties - Preferred Bookkeeping			1999	2,225	222	20	111	(111)	501	24
25	Allocation SIR Properties - Preferred Bookkeeping			2002	70	-	20	3	3	5	25
26											26
27	Allocation SIR Management			1993	13,711	382	20	690	308	7,478	27
28	Allocation SIR Management			1994	43	-	20	4	4	40	28
29	Allocation SIR Management			1995	313	-	20	16	16	132	29
30	Allocation SIR Management			1999	1,489	-	20	75	75	314	30
31	Allocation SIR Management			2000	899	-	20	45	45	166	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 100,063	$ 3,414		$ 3,948	$ 534	$ 33,632	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 735,881	$ 2,357	$ 63,899	$ 61,542	10	$ 583,343	71
72	Current Year Purchases	203,551	165,142	9,380	(155,762)	10	9,195	72
73	Fully Depreciated Assets	46				10	46	73
74								74
75	TOTALS	$ 939,478	$ 167,499	$ 73,279	$ (94,220)		$ 592,584	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,407,765	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 442,257	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 439,123	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,134)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,795,891	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 3,711 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation Preferred Bookkeeping		$	$ 2,516	17
18	Allocation SIR Management			5,074	18
19					19
20					20
21	TOTAL		$	$ 7,590	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 154,905	$		$ 154,905	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			48,805			48,805	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			140,215			140,215	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				198,098		198,098	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			98,271		59,516	171,618		329,405	13
14	TOTAL			$ 98,271		$ 403,441	$ 369,716		$ 871,428	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 68,764	$ 68,765	1
2	Cash-Patient Deposits	60,819	60,819	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,396,468	2,396,468	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		2,040	5
6	Prepaid Insurance	33,011	33,011	6
7	Other Prepaid Expenses	737	737	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	412,289	412,289	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,972,088	$ 2,974,129	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		727,991	13
14	Buildings, at Historical Cost		10,419,509	14
15	Leasehold Improvements, at Historical Cost	531,532	531,532	15
16	Equipment, at Historical Cost	1,237,889	1,972,889	16
17	Accumulated Depreciation (book methods)	(1,164,972)	(4,724,979)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		131,115	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 604,449	$ 9,058,057	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,576,537	$ 12,032,186	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 298,398	$ 298,398	26
27	Officer's Accounts Payable	31,180	31,180	27
28	Accounts Payable-Patient Deposits	76,894	76,894	28
29	Short-Term Notes Payable	1,325,000	1,325,000	29
30	Accrued Salaries Payable	301,612	301,612	30
31	Accrued Taxes Payable (excluding real estate taxes)	48,719	48,719	31
32	Accrued Real Estate Taxes(Sch.IX-B)	429,000	429,000	32
33	Accrued Interest Payable	1,392	1,392	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	103,535	103,535	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,615,730	$ 2,615,730	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		11,882,500	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,882,500	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,615,730	$ 14,498,230	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 960,807	$ (2,466,044)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,576,537	$ 12,032,186	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 535,850	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 535,850	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	424,957	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 424,957	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 960,807	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,211,702	1
2	Discounts and Allowances for all Levels	(10,484)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,201,218	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,070,140	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,070,140	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	175,073	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,556	19
20	Radiology and X-Ray	21,660	20
21	Other Medical Services	184,998	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 409,287	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	587	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 587	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	17	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,681,249	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,459,498	31
32	Health Care	3,467,941	32
33	General Administration	2,022,795	33
	B. Capital Expense		
34	Ownership	1,300,493	34
	C. Ancillary Expense		
35	Special Cost Centers	871,428	35
36	Provider Participation Fee	134,137	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,256,292	40
41	**Income before Income Taxes (line 30 minus line 40)****	424,957	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 424,957	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,977	3,058	$ 101,289	$ 33.12	1
2	Assistant Director of Nursing	961	1,040	25,641	24.65	2
3	Registered Nurses	43,458	45,899	1,165,781	25.40	3
4	Licensed Practical Nurses	8,162	9,685	193,412	19.97	4
5	Nurse Aides & Orderlies	103,633	108,640	940,094	8.65	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,917	5,009	98,271	19.62	7
8	Rehab/Therapy Aides	5,547	5,955	73,877	12.41	8
9	Activity Director	2,791	2,975	38,263	12.86	9
10	Activity Assistants	8,025	8,352	55,405	6.63	10
11	Social Service Workers	7,968	8,509	100,017	11.75	11
12	Dietician					12
13	Food Service Supervisor	1,455	1,521	20,862	13.72	13
14	Head Cook	6,134	6,531	52,670	8.06	14
15	Cook Helpers/Assistants	22,303	23,709	192,337	8.11	15
16	Dishwashers					16
17	Maintenance Workers	4,107	4,226	50,723	12.00	17
18	Housekeepers	31,446	33,057	229,849	6.95	18
19	Laundry	6,761	6,999	47,593	6.80	19
20	Administrator	1,812	2,086	89,032	42.68	20
21	Assistant Administrator	1,894	2,092	46,544	22.25	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,893	10,502	109,787	10.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	9,485	10,180	156,910	15.41	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	283,729	300,025	$ 3,788,357 *	$ 12.63	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly Fee	$ 15,000	01-03	35
36	Medical Director	Monthly Fee	12,800	09-03	36
37	Medical Records Consultant	43	4,128	10-03	37
38	Nurse Consultant		48,516	10-03	38
39	Pharmacist Consultant	Monthly Fee	2,522	10-03	39
40	Physical Therapy Consultant	91	6,200	10a-03	40
41	Occupational Therapy Consultant	151	10,212	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		289	10a-03	43
44	Activity Consultant	41	1,968	11-03	44
45	Social Service Consultant	83	4,278	12-03	45
46	Other(specify)				46
47	Director of Food Services	Monthly	24,996	01-03	47
48					48
49	TOTAL (lines 35 - 48)	409	$ 130,909		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	6,686	$ 240,681	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	37	786	10-03	52
53	TOTAL (lines 50 - 52)	6,723	$ 241,467		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lori Barrish	Administrator	2.04	$ 89,082
Caryl Kiser	Asst. Administrator	0	46,494
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 135,576

B. Administrative - Other

Description	Amount
Management Fees - Dir. Of Administrative Services	$ 30,876
Administrative Charges - Ancillary & Dues	55,092
SIR Management - Management Fees	481,847
See Supplemetal Schedule	4,320
TOTAL (agree to Schedule V, line 17, col. 3)	$ 572,135
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 14,317
Preferred Bookkeeping	Accounting	28,150
Chuhak & Tecson	Accounting	630
ICS Solutions	Computer	180
LTC Solutions	Computer	1,320
Personnel Planners	Unemployment Consulting	1,860
Mort Cohen	Purchase Consultant	1,725
Preferred Bookkeeping	Bookkeeping	88,200
Preferred Bookkeeping	Computer	5,880
Foley & Lardner	Legal	7,557
Michael Best & Friedrich	Legal	31,417
See Supplemetal Schedule		17,215
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 198,452

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,200
Unemployment Compensation Insurance	58,357
FICA Taxes	281,058
Employee Health Insurance	61,368
Employee Meals	38,150
Illinois Municipal Retirement Fund (IMRF)*	
401K Plan	7,400
Employee Benefits Other	9,221
Union Health & Welfare	75,150
CCS Employee Group Benefit	(396)
TOTAL (agree to Schedule V, line 22, col.8)	$ 605,508

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13,832
Health Care Worker Background Check	
(Indicate # of checks performed 162)	1,939
Advertising & Promotion	25,986
IL Council Dues	8,307
Licenses & Fees	1,408
Yellow Page Advertising	16,081
Allocated Preferred Bookkeeping	223
See Supplemental Schedule	92
Less: Public Relations Expense	( )
Non-allowable advertising	(25,986)
Yellow page advertising	(16,081)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,801

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,379
Allocation Preferred Bookkeeping	188
Allocation SIR Management	385
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,952

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Elmwood Care # 0040410 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC - $11,312.00**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,323** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **134,137**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **38,150** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%In14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.